The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

Name: _____

SSN: _____

Date: _____

GROUP ADULT FOSTER CARE ELIGIBILITY

This notice is sent in response to your request for approval of MassHealth payment of group adult foster care (GAFC) services. In order to qualify for MassHealth payment of GAFC services, you must be both clinically and financially eligible for services. *This notice is about your clinical eligibility.* You will receive a separate notice about your financial eligibility.

1. MassHealth Screenings

Screenings to determine clinical eligibility for GAFC services are conducted by _____, Aging Services Access Point (ASAP) on behalf of MassHealth. The ASAP nurse reviewed your case in accordance with MassHealth GAFC Guidelines, and has determined:

☐ you **are** clinically eligible for MassHealth payment of GAFC services. Your continued eligibility is subject to review.

☐ you **are not** clinically eligible for MassHealth payment of GAFC services, because the level of medically necessary services that you require is less than that required for MassHealth payment of GAFC services, as set forth in GAFC Guidelines.

2. Appeal Rights

You have the right to appeal this decision. (Please see attached information about your right to appeal through the Fair Hearing process.)

OFFICIAL USE ONLY

Code: _____ _____ **RN**
ASAP on behalf of MassHealth

Date: _____